We bring it all together for you

Medical Home Interviews

Presentation to KHPA Medical Home Stakeholder Group

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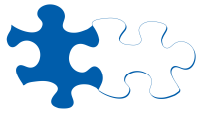
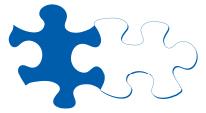
Discussion Topics

- Project Background
  - Medical Home Task Force
  - Establish Provider Practice Baseline
- Selection Process
- Structured Interview
- Response Survey
- Interview Results
- Survey Responses
- Conclusions



Project Description

- Medical Home Task Force
  - CMFHP considers the Medical Home to be a key part of an integrated care delivery system
    - Established work group to explore development opportunities
    - Leadership from Health Services, Provider Relations, Government Affairs, and Finance
    - Ma'ata Touslee, Chief Clinical Officer, chairs the effort
  - Began early in 2008



Project Description

- Group education:
  - Literature review
  - Joined Patient-Centered Primary Care Collaborative (PCPCC), attended conference
  - Attended Institute for Healthcare Improvement
  - Reviewed NCQA material and standards
- Identified a need to collect data on current practices in network, conduct gap analysis

Group Selection Process

- Shared significance
  - Significant membership with CMFHP and an important segment of group's practice
- Diverse geography and setting
  - Scattered over network
  - Urban, suburban, rural
- Identified 12 practices

Group Selection Process

- Contacted by Dr. Peterson to explain initiative, and solicit participation
  - Commit to 90 minutes of interview/discussion time
  - Attendance by three key office leaders
    - Lead physician, business manager, nurse manager
    - Additional providers welcome
- Two staged communication
  - Initial background information and written review of discussion
  - Additional material when meeting scheduled

Group Selection Process

- Initial material
  - KS legislative definition of Medical Home
  - Two documents from NCQA:
    - Physician Practice Connect, Patient Centered Medical Home (PPC-PCMH) document
    - Overview of the NCQA review and certification process

Selection Process

- Material provided prior to the interview
  - Joint Principles of the Patient-Centered Medical Home (AAP, AAFP, ACP, AOA)
  - Demographic survey
  - Survey on NCQA standards
  - Agenda for the meeting

Structured Interview

- To have comparable information, CMFHP task force developed a standardized interview format
  - Initially, based on the NCQA survey
  - Revised after 2 interviews to use the Joint Principles as discussion areas
  - Open ended style to allow ample time for dialogue

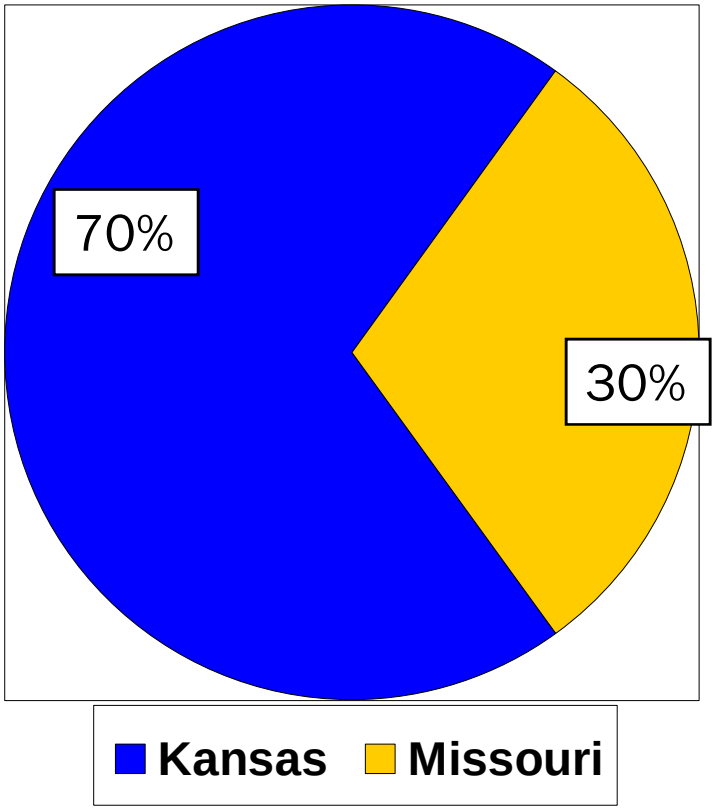
Interview

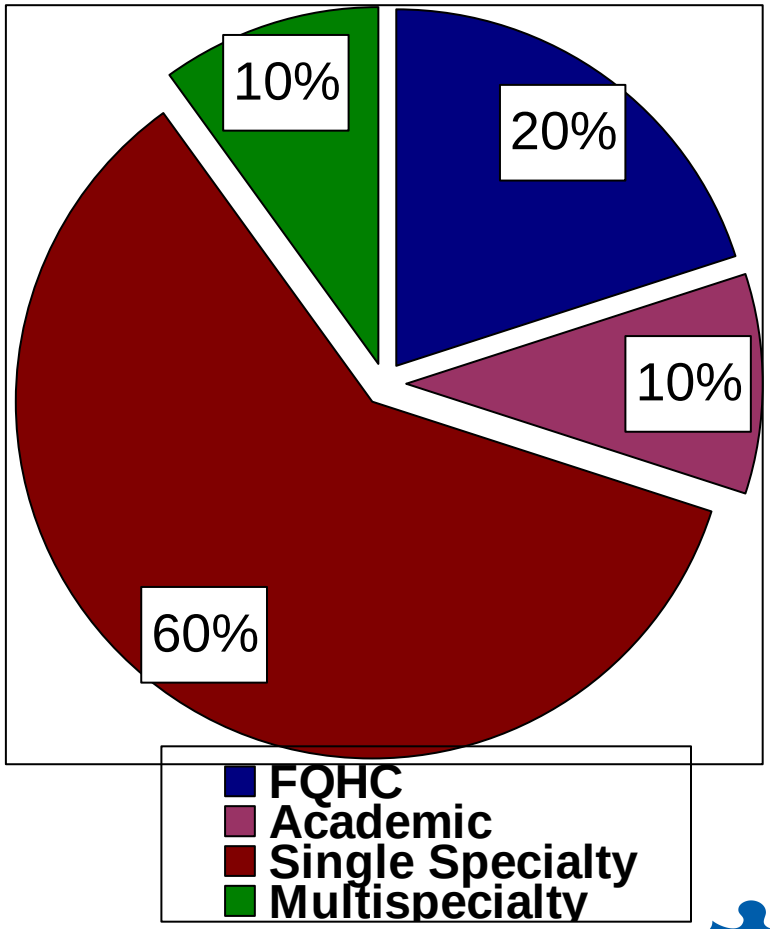
- All interviews attended by either Ms. Touslee or Dr. Peterson; both attended 8 of 10
  - Conducted between August and October 2008
- CMFHP had 2-4 staff at each interview
- Post survey conducted based on the NCQA standards
  - Asked to rate each statement on the perceived value and the practice capability
  - Survey option either paper or electronically (Survey Monkey®)

Results

- 10 interviews completed
  - Geography: Kansas City metro (4); Leavenworth, Lawrence, Topeka, Manhattan, Chanute, Wichita
  - Majority Urban or Semi-urban
  - Ave of 6 physicians per practice (range 1 – 15)

Group Characteristics





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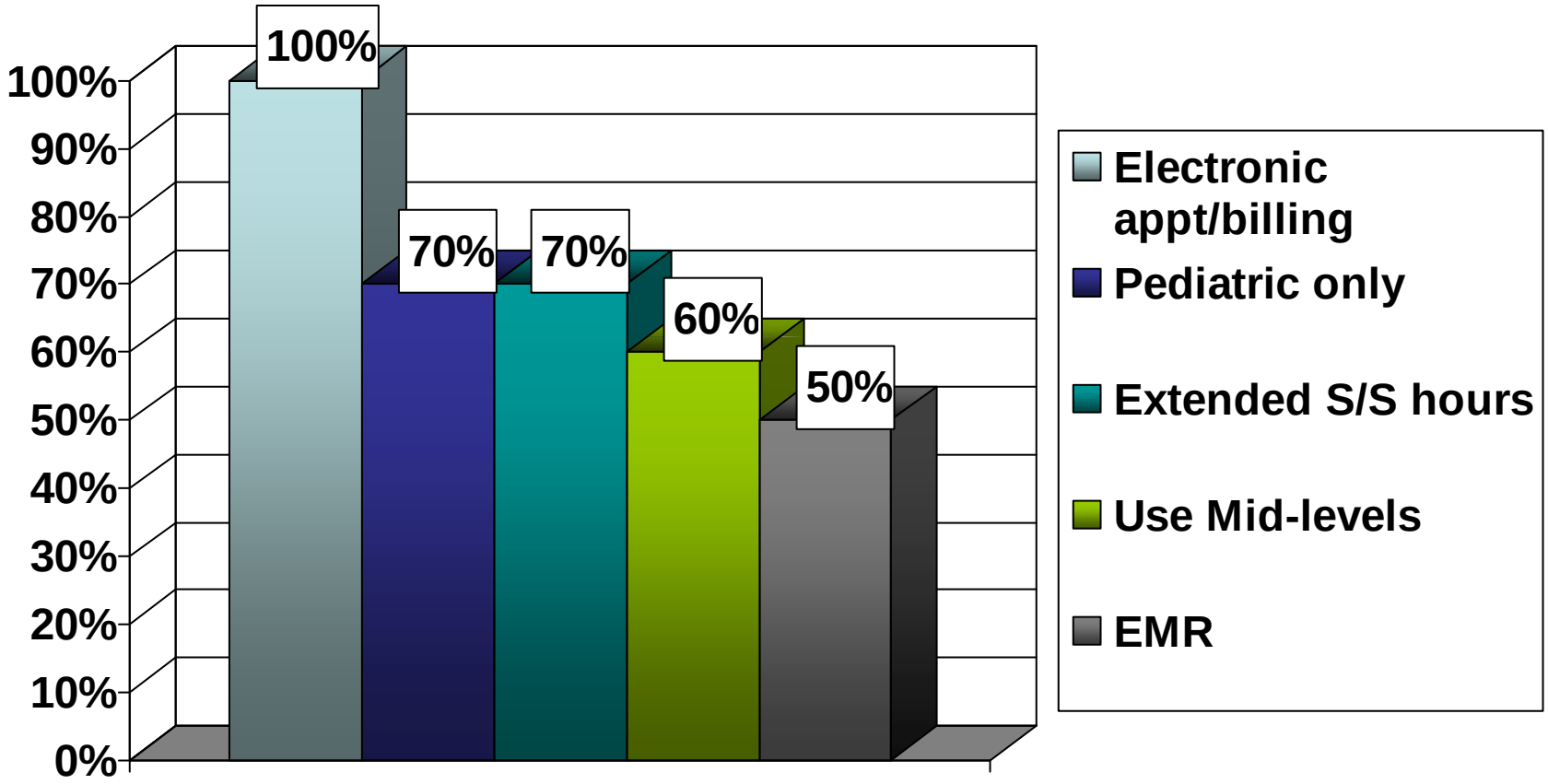

Common Themes

- Medical Home is important
  - All practices feel they have components of medical home
  - All perceive their patients appreciate a practice home
- Highly likely to receive hospital information
- Receipt of specialist information is sporadic and not timely
- Practices with EMR do not typically use reminder functions for prevention or disease management

Common Themes

- No practices do proactive outreach to bring patients in for services
  - One FQHC does do this for diabetic members
  - None believe reminder mailers are helpful
  - No practice newsletters
- No practice is reimbursed for non-face to face care
- Most have no formal process to identify or implement practice guidelines or improvement projects

Common Themes

- Top wasted efforts
  - Practice management or payor reports on performance that are delayed, confusing, or not explained clearly
  - Community Health Record: no practice reported any patient requests for information in this format
- Top important medical home components
  - Care coordination
  - EMR upgrades and integration

Barriers to a High Functioning Medical Home Practice

- Staff required for contacts, coordination of care, outreach
- EMR: cost and system selection, lack of interaction with other systems
- Space constraints
- Lack of electronic interface with outside systems
- Patient expectation of convenience can decrease the cooperation with coordinating all services through a medical home

Payment Structure

- Discussed payment options
  - FFS, based on encounters
  - PMPM
  - Tier payment based upon components practice has and performance
  - Severity rating
- Most favored a hybrid reimbursement method, blending PMPM with an enriched fee schedule

Post Visit Survey Responses

- 90% of practices responded; 13 individual responses
- Highest value to the practice
  - Track tests and abnormal results systemically
  - Use data system for pt demographic information
  - Use a system for organizing clinical information
  - Clinical data system
- Top current practice capabilities
  - Data system for demographic information
  - System for organizing clinical information
  - Support patient self-management

Areas of High Value and Low Practice Capacity

- Generate lists of pts that reminds clinician and pt of services needed
- Generate reminders about needed preventive services
- Provide care management, conduct and monitor care plans
- Electronic prescriptions
- Track referrals
- Electronic order for tests, retrieve them, flag duplicates
- Assess physician performance
- Survey patient experience

Conclusions

- Good acceptance of the Medical Home concept
- Support for improved reimbursement
- Limited penetration of EMR
  - Practices with EMR are not using all functionality
- Poor outreach to patients that are overdue for care, either preventive or chronic disease
  - Common perception that pt responsibility is undermined if practice assumes outreach role

Conclusions

- Over-estimation of existing medical home capabilities when compared to NCQA standards
- Strong commitment to underserved and indigent population
- Need assistance with care coordination, particularly monitoring referral compliance, specialty reports